Questions and Answers

1915 (b)/(c) Medicaid Waiver
Request for Applications
April 21, 2011

Questions about the RFA

#	Source	Question & Reference	Answer
1	Crossroads	**Application Due Date**: Based on the rapid process and significant operational detail required for the Request For Application, will DHHS (DMA and DMHDDSAS) consider a change to the application due date, moving it to 6/30/2011?	No.
2	Eastern Alliance (Cumberland, Johnston, Southeastern Regional, Southeastern Center, Beacon Center, Eastpointe, Onslow Carteret)	**Application Due Date:** Will the Department of Health and Human Services and Division of Medical Assistance consider moving back the deadline for submission of applications to allow for LME's who are trying to merge or form other relationships sufficient time to plan and submit their applications? (5 weeks is short time frame to design mergers between multiple LME's). Six months would allow a more reasonable time frame to create plans that impact multiple stakeholders.	No.
3	Pathways	**Application Due Date:** Based on the rapid process and significant operational detail required for the RFA application, will DHHS (DMA and DMH/DD/SAS) consider a change to the Application due date, moving it to 6/30/2011?	No.
4	Guilford Center	**Application Due Date:** If an LME plans to partner with a lead LME who has already been selected as a waiver site, what needs to be submitted by May 20?	The lead LME must submit a full application.

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5	Crossroads	**Scope of Work:** Is the intended outcome of the Request For Application process to reduce the overall number of LMEs or to have the same number of LMEs, but with some functioning as an MCO and others holding other functions? Stated differently, if an LME is not the lead LME, will they still be considered an LME?	The intended outcome of the RFA is to implement the 1915 (b)(c) Medicaid waiver statewide. No.
6	Smoky Mtn	**Scope of Work:** p. 16 Terms such as "care management" or "customer services" may differ…"customer services" is not included in the definition listing, can you please tell us the definition.	Customer Services are defined in the DMA Contract, section 6.7. All of these required functions are clearly outlined in the DMA contract.
7	Crossroads	**Organizational Arrangement:** In the instance of two or more LMEs plan to merge, can that proposed merged group respond to the Request For Application as if it is already merged? If so, how should the application be submitted (jointly by all proposed merging parties; by one of the proposed merging parties on behalf of all parties)?	Yes, the merged group needs to respond as if they are already one entity. The application should be submitted as if one LME. The composition of the LMEs should reflect the Minimum Requirements as outlined in the RFA.
8	Crossroads	**Organizational Arrangement**: In the instance of a proposed merger, should responses to minimum requirements be reflective of each individual party to the merger?	No, the application should reflect the combined new entity.
9	Five County MHA LME	**Organizational Arrangements:** Five County and OPC are pursuing plans to partner with PBH and have the PBH Waiver extend to the Five County and OPC catchment areas. Is PBH, Five County or OPC expected to respond to the RFA? If not, what information will need to be provided in order for these LME's to secure this plan.	PBH should submit a letter of intent to the State with letters of support from Five County and OPC.

#	Source	Question & Reference	Answer
10	MH Partners	**Organizational Arrangement:** In the narrative on Minimum Requirements in the RFA document, there is a statement that DHHS will assign LMEs if LMEs do not define partnerships (for managed care and LME functions by January 1, 2013). If that LME is under eligibles/ population criteria, would it maintain its LME certification and contract with the Division?	If the LME has not identified an affiliation at the time of January 2013, or meet the population requirement of 300,000 or 500,000 as identified in RFA minimum requirements #1, the LME will be assigned by DHHS.
11	Eastern Alliance	**Organizational Arrangement:** What happens to those LMEs under 122c that do not become waivers or primary services providers and is there any LME funding that will come to the "Legacy LME?"	On page 11 of the RFA there are three proposed models that can be considered for application. The future of the LMEs is based upon the organizational arrangement selected. All funding goes to the lead LME.
12	Eastern Alliance	**Organizational Arrangement:** What signatures are needed for the RFA when LMEs are forming partnerships? It is not clear what is needed from the additional counties relative to support, signatures, buy in for one LME to be the lead LME.	A letter from each respective board signed by the board chair is sufficient to meet this requirement. The lead LME must submit and sign the application.
13	Eastern Alliance	**Organizational Arrangement:** How will stakeholder meetings need to be configured as partnerships are being established?	The lead LME needs to ensure that all policies related to stakeholder meetings. The application should demonstrate representation of all parties involved.
14	Eastern Alliance	**Organizational Arrangement:** Please clarify LME functions for non-waiver LMEs through use of an inter-local agreement with the waiver LME – are there restrictions on this?	The functions of each LME are based upon the organizational arrangement submitted by the lead LME that are within the guidelines of the RFA.
15	Eastern Alliance	**Organizational Arrangement:** How will the governance model for an LME need to change in response to the waiver?	The governance model remains the same as the business functions, although responsibilities are expanded.

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16	Eastern Alliance	**Organizational Arrangement:** Are there restrictions on Legacy LME's providing services?	An LME may not provide direct services.
17	Eastern Alliance	**Organizational Arrangement:** Is DMH approval required for an LME to provide services?	An LME may not provide direct services.
18	Eastern Alliance	**Organizational Arrangement:** Can a legacy LME become a CABHA?	Any entity applying to be a CABHA must meet all DMA and DMHDDSAS requirements. An LME may not provide direct services.
19	Eastern Alliance	**Organizational Arrangement:** How will a local presence be accomplished in the models being proposed?	The functions of each locality are based upon the organizational arrangement selected by the lead LME. It is the lead LME's responsibility to build upon the structure that was created by LMEs in their catchment areas.
20	Eastern Alliance	**Organizational Arrangement:** If a non-waiver LME joins with another LME that is applying to be a waiver and for some unforeseen reason they are not chosen, where would that leave the non-waiver LME? Would that non-waiver LME be given the opportunity to negotiate with another LME of their choice or will it be too late or would they simply be assigned?	If LMEs do not identify working partners, then DHHS will assign LME catchment areas to the chosen LME-MCO vendors for both DMA managed care and LME functions by January 1, 2013.
21	Guilford Center	**Organizational Arrangement:** Are there any functions that the non-lead LME could not negotiate to perform under an intra-governmental agreement with the lead LME?	The functions of each LME are based upon the organizational arrangement selected submitted by the lead LME and within the guidelines of the RFA.
22	Eastern Alliance	**Organizational Arrangement:** If a non-waiver LME joins with another LME that is applying to be a waiver and for some unforeseen reason they are not chosen, where would that leave the non-waiver LME? Would that non-waiver LME be given the opportunity to negotiate with another LME of their	If LMEs do not identify working partners, then DHHS will assign LME catchment areas to the chosen LME-MCO vendors for both DMA managed care and LME functions by January 1, 2013.

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		choice or will it be too late or would they simply be assigned?	
23	Guilford Center	**Organizational Arrangement:** Are there any functions that the non-lead LME could not negotiate to perform under an intra-governmental agreement with the lead LME?	The functions of each LME are based upon the organizational arrangement selected submitted by the lead LME and within the guidelines of the RFA.
24	Guilford Center	**Organizational Arrangement:** Under an intra-governmental agreement, we believe that the non-lead LMEs would retain their own Board and CFAC. Do you view this differently? What would their relationship be with their lead counterparts?	The functions of each LME are based upon the organizational arrangement selected submitted by the lead LME and within the guidelines of the RFA.
25	Guilford Center	**Organizational Arrangement:** Under an intra-governmental agreement, what Board and CFAC representation are required from the non-lead LMEs?	The functions of each LME are based upon the organizational arrangement submitted by the lead LME that are within the guidelines of the RFA.
26	Pathways	**Organizational Arrangement:** Referencing the governance criteria on page 11 of the RFA, is the intended outcome of the RFA process to reduce the overall number of LMEs or to have the same number of LMEs, but with some functioning as an MCO and others holding other functions? Said differently, if an LME is not the lead LME, will they still be considered an LME?	The intended outcome of the RFA is to implement the 1915 (b)(c) Medicaid waiver statewide. No.
27	Crossroads	**Implementation Date:** Based on the significant governance changes that may occur as part of the implementation, will DHHS (DMA and DMHDDSAS) consider a change of the full implementation of 1915(b)/(c) to be 7/1/2013? That would provide two merger opportunities for LMEs (merger has to occur at the start of a State fiscal year).	No.

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28	MH Partners	**Implementation Date:** Will DMA and DMHDDSAS consider a final implementation/operational date of July 1, 2013 (rather than January 1, 2013) so that there are two changes for a merger, if needed? Mergers can only occur at the start of a fiscal year.	No.
29	Pathways	**Implementation Date:** Based on the significant governance changes that may occur as part of the implementation, will DHHS (DMA and DMHDDSAS) consider a change of the full implementation of 1915(b)/(c) to be 7/1/2013? That would provide 2 merger opportunities for LMEs (merger has to occur at the start of a State fiscal year).	No.
30	Eastpointe	**Implementation Date:** Is the expectation that selected LMEs will begin full implementation as a Waiver site beginning January 1, 2013 or July 1, 2013? We are hearing that it will not take effect until July 1, 2013; however, the RFA says January 1, 2013.	January 1, 2013.
31	Eastpointe	**Minimum Requirements:** If the Lead LME (applying LME) has transferred all responsibility for guardianship; however, the LME they are partnering with still has guardianship responsibility, by when will the remaining guardianship cases need to be transferred?	Cases must be transferred before the effective date of a merger. The LME-MCO may not serve as guardian for any Medicaid enrollee.
32	Eastpointe	**Minimum Requirements:** We would like clarification of the conflict of interest as it relates to "familial" relationships. What is the definition of "familial" – spouse, children, parents, aunts, uncles, cousins? How far does it extend and still be problematic?	• Husband and wife; • Natural or adoptive parent, child, and sibling; • Stepparent, stepchild, stepbrother, and stepsister; • Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; • Grandparent and grandchild; and • Spouse of grandparent & grandchild.

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33	Eastpointe	**Minimum Requirements:** If the provider is paid solely from county funds and no state or federal funding are utilized, does this "familial" rule apply?	The LME-MCO may not serve as guardian for any Medicaid enrollee.
34	MH Partners	**Minimum Requirements:** The RFA requires that Governing Boards, Boards of Commissioners and CFACs understand, agree, and support in writing the proposed merger/consolidation plan of applying LMEs. The May 20, 2011 submission date does not allow for that to happen, given the brief time allowed from the publishing of the RFA on April 1, 2011. What provisions are to be made for that lack of appropriate time for scheduled governmental entities to meet and process such a significant decision? Is not June 30, 2011 more appropriate?	An application submitted without meeting the Minimum Requirements will not be considered. A letter from each respective LME board signed by the board chair is sufficient to meet this requirement.
35	Crossroads	**Minimum Requirements:** Minimum Requirement #7 requires that "The applying LME provide a letter of intent, signed by all parties, describing the relationship of the parties with respect to management and business functions, roles and financial arrangements within the newly proposed MCO. The letter of intent among two or more LMEs will also specify the commitment to merge or the commitment to designate the lead LME and subcontracted LME functions performed by other LMEs in the agreement." If the LMEs agree to designate the lead LME, are the subcontracted LMEs required to meet the population minimums of 300,000 (2012) and 500,000 (2013) to remain certified as LMEs/?	The population numbers within the catchment areas of the lead LME plus the partner LMEs must meet the total population criteria.
36	Crossroads	**Minimum Requirements:** If the agreement referenced in Minimum Requirement #7 is to designate a lead LME and several other LMEs will	A letter from each respective LME board signed by the board chair is sufficient to meet this requirement.

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		subcontract rather than merge, will a letter of intent from the subcontracted LME boards be sufficient to meet the requirement of intent, or do the respective boards of county commissioners need to vote in support of the intent?	
37	Crossroads	**Minimum Requirements:** The Request For Applications requires that Governing Boards, Boards of County Commissioners and CFACs understand, agree, and support in writing the proposed merger/ consolidation plan of applying LMEs. The May 20, 2011 submission date does not allow sufficient time for these various bodies to convene, review, understand, agree and support a plan. What provisions are to be made for the lack of appropriate time for scheduled governmental entities to meet and process such a significant decision?	An application submitted without meeting the Minimum Requirements will not be considered. A letter from each respective LME board signed by the board chair is sufficient to meet this requirement.
38	Crossroads	**Minimum Requirements**: If an LME is under the criteria for eligibles/ population, will the LME remain as an LME (retain certification and contract)?	No.
39	Crossroads	**Minimum Requirements:** Under the lead LME scenario, are non-lead LMEs required to meet the 300,000-500,000 population benchmarks (without including any population from partner LMEs)?	The population numbers within the catchment areas of the lead LME plus the partner LMEs must meet the total population criteria.
40	Centerpoint	**Minimum Requirements Checklist:** Appendix C: Minimum Requirements Checklist, #6: Minutes of the Board meeting where the action item was discussed and the vote taken shall accompany the letter of support from the LME Board to approve and obligate the resources required to develop the infrastructure to operate the PIHP and to	Yes.

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		assume the financial responsibilities for operating the PIHP. Given the time constraints, are draft Minutes acceptable?	
41	Cumberland County MH	**Minimum Requirements:** Please define Employer's Liability Insurance as required in the RFA.	As stated in Minimum Requirements #10.
42	MH Partners	**Minimum Requirements:** If an applicant meets all the "Minimum Requirements" by proposing a new organizational arrangement (a merger or intra-governmental agreement), and other sections of the application indicate clear understanding and willingness to accommodate all business requirements despite incomplete details (due to necessary development of a new organizational design), will the application still be granted consideration for moving forward?	If an application meets all minimum requirements, a desk review will be completed.
43	Eastern Alliance	**Minimum Requirements:** If an LME is working toward merger with another LME and the non-surviving LME's accreditation is scheduled to be renewed within 9 months of the merger completion will there be a waiver from this requirement available?	The LME that is the MCO or the lead LME of the MCO must be accredited. Any LME providing managed care functions in a partnership must also be accredited.
44	Guilford Center	**Minimum Requirements:** Could a non-lead LME retain basic benefit services? If not, by when must divestiture occur?	Only approved provider agency types may provide Medicaid and state-funded services. An LME may not provide direct services. All services must be divested by the date of the application.
45	Guilford Center	**Minimum Requirements:** Can a lead LME, with less than 70,000 covered lives, apply if their application includes an agreement with one or more other LME's with a combined total of more than 70,000?	The population numbers within the catchment areas of the lead LME plus the partner LMEs must meet the total population criteria.

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46	Guilford Center	**Minimum Requirements:** Can a lead LME with less than 500,000 population apply if their application includes an agreement with one or more other LMEs with a combined total of more than 500,000?	The population numbers within the catchment areas of the lead LME plus the partner LMEs must meet the total population criteria.
47	Guilford Center	**Minimum Requirements:** If an LME is unable to fully divest by May 20, but has a signed agreement with a community provider to transition consumers, would the application be considered?	No.
48	Guilford Center	**Minimum Requirements:** To provide a smooth transition of consumers, if an LME is unable to fully divest by May 20, would an application be considered if it included a firm RFP plan and set dates to transition consumers to the new provider?	No.
49	Pathways	**Minimum Requirements:** Page 11 of the RFA document describes organizational arrangements. Under the lead LME scenario, do non-leads have to meet the 300,000-500,000 population benchmarks (without including any population from partner LMEs)?	The population numbers within the catchment areas of the lead LME plus the partner LMEs must meet the total population criteria.
50	Pathways	**Minimum Requirements:** The RFA states that neither the LME, nor any employee of the LME shall serve as legal guardian for any recipient of Medicaid MH/DD/SA services. What if the ward for the guardian has Medicaid but does not use MH/DD/SA services? What if the ward does not have these services at the time that the employee is hired but then gets and uses Medicaid MH/DD/SAS benefits?	The LME-MCO may not serve as guardian for any Medicaid enrollee.

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51	Eastpointe	**Minimum Requirements:** Do the legal issues in the RFP apply just to the applying LME or to all the LMEs that will be merging with the lead?	All LMEs in a merger would need to disclose any legal issues.
52	Pathways	**Standardization:** Page 14 of the Request for Applications—"Note that DHHS will require consistency in the administration of the 1915 (b)/(c) waiver across the State through basic guidelines and requirements such as credentialing, utilization management, data management, reporting, performance measures, and other key functions. To this end, DHHS has adopted the PBH model of managed care operations. The following forms and business processes will be standardized." Where and when do we get the referenced standardized forms and business processes?	PBH has offered to share their forms, policies, and procedures to LMEs that will sign a non-disclosure agreement. Upon selection, DHHS will ensure that all LME-MCOs have the appropriate forms, policies, and procedures.
53	Smoky Mtn	**Standardization:** The RFA states that the state will use a variety of PBH forms and processes do ensure consistency across LME's. Will these forms and process descriptions be available for use in submitting the Waiver application?	PBH is making forms available to other LMEs who sign a non-disclosure agreement. DHHS will work with LME-MCOs to make sure that the PBH model is standardized.
54	Smoky Mtn	**Standardization:** Will the PBH dashboard reporting format(s) and c Waiver reporting format and related data elements of both, be available for use in submitting the Waiver application? When will they be available?	PBH is making forms available to other LMEs who sign a non-disclosure agreement. DHHS will work with LME-MCOs to make sure that the PBH model is standardized. The reporting formats will be standardized. Please see the DMA contract for required reporting elements.
55	Eastpointe	**Standardization:** The RFA mentions standardizing certain forms and business processes that PBH currently has in place. Can we get copies of those forms and processes so that we can begin to implement them?	PBH has offered to share their forms, policies, and procedures to LMEs that will sign a non-disclosure agreement. Upon selection, DHHS will ensure that all LME-MCOs have the appropriate forms, policies, and procedures.

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56	Crossroads	**Application Narrative:** Is it permissible to propose that full evaluation of Information Technology systems will be undertaken and a selection will be made by date certain?	No. Per minimum requirement #11, the LME applying to operate a PIHP must possess or have subcontracted for the automated management information system they will use to perform all MCO activities.
57	Crossroads	**Application Narrative:** If an applicant successfully meets ("passes") the "Minimum Requirements and Financial Status and Viability" but is not successful in "Clinical Operations," "Administrative Operations," and "Implementation Plan," is it possible for the applicant to move forward, pending some corrective actions?	No.
58	Crossroads	**Application Narrative:** Is it permissible to answer some detailed aspects of the Request for Application as: "Details of compliance with the standard will be forthcoming upon completion of _____."?	No.
59	Pathways	**Application Narrative:** Is it permissible to answer some detailed aspects of the Request for Application as: "Details of compliance with the standard will be forthcoming upon completion of _____."?	No.
60	Pathways	**Application Narrative:** If an applicant successfully meets ("passes") the "Minimum Requirements and Financial Status and Viability" but is not successful in "Clinical Operations," "Administrative Operations," and "Implementation Plan," is it possible for the applicant to move forward, pending some corrective actions?	No.

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61	Crossroads	**Clinical Operations:** How much leeway will be allowed to develop best practice and innovative services that may be outside the service definitions for routine and fee for service practices?	MCOs are required to oversee delivery of Medicaid State plan services and CMS-approved b3 services. MCOs will work with the State in the future as we look at the efficacy of current services.
62	Crossroads	**Clinical Operations:** As a Medicaid Vendor, will we be "married" to service definitions?	The Medicaid State Plan Amendment services must be utilized.
63	Crossroads	**Clinical Operations:** What is meant by the Provider "profiling" definition? Please provide an example?	This is the term for the PBH 'provider report card' model that will be used by all new MCOs.
64	Crossroads	**Clinical Operations:** Who will actually do Provider credentialing for the Medicaid Provider Network?	The LME-MCO. New MCOs must use the PBH model. CMS requires a statewide, uniform credentialing process. A specific definition is not given in the RFA. In general terms it refers to a pattern of assessing patterns and activities for provider monitoring.
65	Eastern Alliance	**Clinical Operations:** Will the lead LME and any that merge with it be permitted to contract with another entity for after hours coverage of the call center?	This function may be subcontracted.
66	Eastern Alliance	**Clinical Operations:** What effect will the RFA have on CABHAs?	CABHAs are considered a part of the provider network. LME-MCOs may choose to develop alternative funding strategies to support CABHAs.
67	Smoky Mtn	**Clinical Operations:** Clinical Services/Utilization Management: Will requests for out-of-state services need to go through DMA or will the LME alone make such determinations?	The LME-MCO makes these determinations.
68	Smoky Mtn	**Clinical Operations:** Clinical Services/Utilization Management: Will the settlement agreement from the	See the due process procedures in Attachment O in the DMA Contract.

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		McCartney v Dempsey lawsuit apply to waiver LMEs? If yes, how will this apply to managed care UR and appeals processes?	
69	Smoky Mtn	**Clinical Operations:** Clinical Operations/Customer Services: Regarding the requirements to confirm that the individual was seen in a timely fashion and to follow-up with individuals that do not show up for appointments: Is it acceptable for the LME to directly follow-up only high risk individuals and require (and oversee) that providers do appropriate follow-up and outreach with routine referrals? What are LME responsibilities? What are provider responsibilities?	The responsibility of the LME-MCO is to describe how they will ensure that this function is carried out. See the DMA Contract, section 6.13. Ultimately, the LME-MCO is responsible.
70	Smoky Mtn	**Clinical Operations:** Care Management: Is the requirement for 24/7 telephonic assessment and crisis response a LME Care Management responsibility or can this be a function of Mobile Crisis Management in the provider network? If no, please clarify the detail of the LME Care Management responsibility.	The responsibility of the LME-MCO is to describe how they will ensure that this function is carried out. Ultimately, the LME-MCO is responsible.
71	Smoky Mtn	**Clinical Operations:** Clinical Services/Utilization Management Will requests for non-covered services under EPSDT need to go through DMA or will the LME alone make such determinations?	The LME-MCO makes these determinations.
72	Smoky Mtn	**Clinical Operations:** Care Management: In section 6.13 in DMA contract requirement: For enrollees with special health care needs who need a course of treatment or regular care monitoring, the MCO shall produce a treatment plan. The treatment plan must meet the following requirements: Developed by enrollees' care manager	The MCO is required to prepare this treatment plan. For MHSA, this is the PCP format and for IDD, the ISP format is to be used. In cases where recipients have treatment plans already (i.e. through a bundled service), the MCO should have a copy of this treatment plan and should collaborate with the provider agency to ensure that

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		with enrollee participation, and in consultation with any specialists' care for the enrollee. Is MCO staff producing a treatment plan or is this a provider function? If this is NOT a provider function, what is the scope of the treatment plan and how does it tie into the individual service plan/PCP? Does this vary by disability and if so, how?	the plan is complete and involves all specialty care. This is a 'care management' function and MCOs are responsible for identifying these individuals and ensuring that they have a treatment plan and coordination of care. This care management function can be episodic, and is dependent on recipient need.
73	Smoky Mtn	**Clinical Operations:** Question: Are care coordinator functions under the Innovations waiver PIHP staff functions, a provider function or can it be either? Please define the specific PIHP care coordination functions and the specific Provider care coordination functions. Will the decision related to the functions described above have any effect on other levels or types of case management?	See the "Care Management" section of the DMA contract (6.13). Also, see response above. When PBH fulfills their care management responsibilities for IDD Special Health Care Populations, they refer to it as 'care coordination.' CMS calls this function, "Managed Care Treatment Planning." (CFR 438.208(c)). This is a care management function of the LME-MCO. The LME is responsible for section 6.13--the Care Management section of the DMA contract—this includes the preparation and oversight of treatment plans for special health care populations, as identified in the contract. TCM is not a service for any disability group under the 1915 b/c waivers. See Appendix K for a list of services included in the capitation.
74	Smoky Mtn	**Clinical Operations:** RFA Attachments: Are job descriptions required for all current positions and planned future positions? Or just for planned future positions as a Waiver site?	The job descriptions requested are for positions within the LME-MCO. These include currently filled positions as well as planned positions.

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75	Smoky Mtn	**Clinical Operations:** Critical Positions: Which positions are deemed critical and are to be filled and trained ninety days prior to going live on the Waiver?	All key positions essential for the development of the LME-MCO are identified in the Facilities and Organization Section of the RFA on pages 25-26.
76	Smoky Mtn	**Clinical Operations:** Customer Services: Regarding the requirement "Conducts follow-up with individuals who do not show up for routine appointments": Does this apply only to initial referrals scheduled through the LME and not to ongoing appointments?	Yes.
77	Smoky Mtn	**Clinical Operations:** Enrollment: When will enrollment data be available for our catchment area?	Upon selection.
78	Pathways	**Clinical Operations:** Page 17-18 of the Request for Applications, Enrollee Education—This section asks for copies of written material, screenshots of website and evidence of consumer and family involvement in resource design/development. We assume that you are requesting a plan for development of these materials rather than a literal reproduction of materials since they have not yet been developed. Is it acceptable to submit a plan and copies of materials (and screenshots) of currently used (non-MCO) resources?	No, unless applicable to LME-MCO functions.
79	Pathways	**Clinical Operations:** Pages 18-19 Section 6.13—Last bullet under Care Management MH says “provides follow-up.” Last bullet under Care Management DD says “provider follow-up.” Is one a typo or under MH/SA care manager’s follow-up and under DD care managers make sure the providers follow-up?	Yes. Should be ‘provides follow-up” in both places.
80	Pathways	**Clinical Operations:** Page 24 of the Request for Applications—Sections on “Appointment Availability” and	The total Provider Network section is limited to 8 pages, as stated on page 23.

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		"Appointment Wait Time" do not have page limits cited for the narrative. Assuming that this is an oversight, what is the page limits for these sections?	
81	Crossroads	**Administrative Operations:** As a Medicaid Vendor, even though you still have LME functions, do you maintain Local Government status regarding benefits?	This is a LME-MCO Board business decision as negotiated as part of a merger agreement.
82	Eastpointe	**Administrative Operations:** Could you provide file layouts of the HIPAA compliant transaction set companion guides that we would be required to utilize for the Waiver?	The LME will receive this information upon selection.
83	Eastpointe	**Administrative Operations:** In section 9.2 (encounter data and claims) it asks for copies of submission reports that are generated during the encounter submission process and enrollment and eligibility reports that demonstrate accurate receipt, processing and reconciliation. Since we are not currently doing these functions how can we provide this data to you? What are you looking for us to provide?	Exactly what is stated on pages 27-28 of the RFA.
84	Crossroads	**Finance**: Please verify that the following is true: The dollars for System Administration equal no more than 9% of Medicaid and IPRS claims and administrative dollars come out of PMPM allocation.	Historically, the dollars for Medicaid general administration range from 8 to 9.5 percent depending upon the finalization of the databook. . Administrative dollars are included in the PMPM capitation.
85	Crossroads	**Finance:** Are 3 Way Contract dollars outside or included within this process?	These funds are outside this process and per legislation cannot be allocated to the LME-MCO.
86	Southeastern Center	**Finance:** The RFA does not specify the funding available therefore how can a respondent identify the exact number of positions needed for each function when the funding is not known?	Calculations for the positions required should be based on operational needs.

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87	Eastern Alliance	**Finance:** How will the PM/PM rate be calculated? The applicants will need this information to determine the staffing pattern and organizational model. When will the funding model for the contracting LME be provided?	Through actuarial calculations based on utilization of Medicaid services over the past three years.
88	Eastern Alliance	**Finance:** When will funding change (Lead LME) (De-allocation) be effective?	The implementation PMPM depends upon the effective start date of the DMA and DMHDDSAS contracts.
89	Eastern Alliance	**Finance:** Will Lead LME receive all funding (IPRS) of the legacy LMEs or will there be an immediate reduction?	Yes, once the contracts are signed the lead LME receives funding based on the PMPM as of the contracted start date.
90	Smoky Mtn	**Finance:** Claims: Will state hospitals be submitting 837 claims for all inpatient services, including Medicaid and state funded?	State hospitals will submit 837i transactions for all inpatient services for Medicaid recipients.
91	Smoky Mtn	**Finance:** What percentage of capitation payment should the MCO use to budget for administrative revenue? Would this include funding for any expanded care management functions/ responsibilities that would be required by the state?	Historically, the dollars for Medicaid general administration range from 8-9.5 percent depending upon the finalization of the databook. Administrative dollars are included in the PMPM capitation.
92	Pathways	**Finance:** Please clarify if the following is true: The dollars for System Administration equal no more than 9% of Medicaid and IPRS claims and administrative dollars come out of PMPM allocation.	Historically, the dollars for Medicaid general administration range from 8-9.5 percent depending upon the finalization of the databook. Administrative dollars are included in the PMPM capitation.
93	Eastern Alliance	**Finance:** What is the liability to a county if there are problems with the waiver? What is the legal process to ensure that counties be held harmless for financial risk related to the waiver? We understand that there is legislation being considered as well as an interpretation from Mark Botts to hold the counties harmless.	The MCOs must provide detailed financial reporting to DMA on a quarterly basis. If at any point, the LME appears to have financial problems, DMA will revoke the Medicaid contract (per contract requirements). We therefore anticipate that MCOs and counties will never be in the position to utilize county dollars for overrun expenditures.

#	Source	Question & Reference	Answer
94	Eastpointe	**Finance:** Is there a defined methodology for the "risk pool" (i.e. - percentage of funds needed to be available, are paid claims used to determine the percentage or size of the risk pool??)	Yes. See Section 1.9 of the DMA contract.
95	MH Partners	**Implementation Plan:** Since the RFA outlines a phasing-in implementation, and supports LME mergers and alliances to achieve the required population requirements, what is the feasibility of phasing-in practical answers to the detailed questions once those mergers or alliances have been made? Otherwise, comments made in 2011 may not be accurate or apply to what is actually implemented in 2013.	An application is the LME's statement of intent and not meant to prevent flexibility outside the State's requirements for standardization should planning determine a different action would be more advantageous to the State.
96	Smoky Mtn	**Implementation Plan:** Appendix D The Implementation Plan has a column titled "Financial Resources" that should be linked to Financial Plan. Should this column reference either the page number(s) where discussed in the Financial Plan, or the section name where this information could be found to link the two?	The page number is sufficient.
97	Smoky Mtn	**Implementation Plan:** Policy & Procedure Manual: Do all policies and procedures that are developed to operate as a MCO have to be formally adopted, or only those where it calls for formal adoption. Can polices and procedures, with the exception of those specifically mandating formal approval, be in draft form?	Yes. Policies and procedures may be in draft format but must relate to LME-MCO functions.
98	Smoky Mtn	**Implementation Plan:** Policy & Procedure Manual Should we submit all current organizational policies and procedures in addition to initial policies and procedures that will be adopted when operating as a MCO? Do policies	Yes. Policies and procedures may be in draft format but must relate to LME-MCO functions.

#	Source	Question & Reference	Answer
		and procedures developed for operation as a MCO need to be formally approved at time of application submission, or can they be submitted as draft policies and procedures?	
99	Eastern Alliance	**Evaluation of Applications:** Will all applications from LME's that meet minimum criteria specified in RFA be selected to contract with DMA to manage a waiver in their region? Or is there a plan to limit the total number of successful LME's to a specific amount?	After minimum requirements are determined to have been met, the LME applying to operate a PIHP must successfully meet criteria for the desk and on site reviews.
100	Eastern Alliance	**Evaluation of Applications:** Will the Department of Health and Human Services and Division of Medical Assistance accept a model of partnership in which multiple LME's form a new governance structure (e.g. ASO) to contract with DMA and collectively manage risk and LME functions for entire region? (Assuming that this arrangement can realize necessary economies of scale/savings). This is not a full merger or model where one LME becomes the lead and others legacy. It is a model where LME's partner to form a new company to act as single contracting entity and coordinate LME functions across partner LMEs.	If the application meets minimum requirements, it will be reviewed.
101	Smoky Mtn	**Contents of the Application:** Each functional area of the Clinical Services and Administrative Operations checklist asks for specific attachments. May additional attachments be included in these functional areas, or should additional attachments be submitted as part of the Appendices?	These items would be submitted in the appendices. However, elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

Questions about the DMA Draft Contract

#	Source	Question & Reference	Answer
1	Centerpoint	**Attachment V "Mixed Services Payment Protocol" from Draft DMA contract, p. 94** Historically and presently, all privately insured, Medicare, and VA admissions to a State Hospital/ADATC authorized by and counted as "Bed Days" for the admitting LME. Under a 1915 (b)/(c) Medicaid waiver would the MCO be responsible for State Hospital/ADATC charges for these populations? If so, does the MCO have the option of denying authorization for admission to a State Operated Healthcare Facility for these populations?	The LME-MCO capitation includes costs for all levels of inpatient psychiatric care for Medicaid enrollees only. Medicaid funding can only be used for treatment in IMDs (state hospitals and ADATCs) for those recipients under the age of 21 and over the age of 65 if treatment is medically necessary. The LME-MCO is only responsible to pay for services authorized as 'medically necessary.' Recipients are always able to appeal those decisions.
2	MH Partners	**DMA Contract, section 7.7** If ICF/MR facilities and their people and dollars are included, does that also take into account the management of the people and dollars at the J. Iverson Riddle Developmental Center? (If so, then the paid claims data needs to be provided.)	The LME manages the Medicaid dollars for admissions. See the DMA Contract, section 7.7. All data is included in the Medicaid databook.
3	Crossroads	**DMA Contract, section 7.7** Does the Request for Application include management of State DD institutions (J. Iverson Riddle Center)? If so, we need the data for what the dollars spent in this area would be (it is not in the Medicaid paid claims file).	The LME manages the Medicaid dollars for admissions. See the DMA Contract, section 7.7. All data is included in the Medicaid databook.
4	Crossroads	**DMA Contract, section 6.21** Does the Request for Application include management of State MH/SA institutions? If so, we need the data for what the dollars spent in this area would be (it is not in the Medicaid paid claims file).	The LME manages the Medicaid dollars for admissions. See the DMA Contract (section 6.21) for those under age 18 and over age 63. All data is included in the Medicaid databook. See the DMHDDSAS Contract for those aged 18-63. Attachment III of the DMHDDSAS Contract states that transfer of funds for state facilities will

#	Source	Question & Reference	Answer
			not occur for the next "xx" years.
5	Smoky Mtn	**DD Innovations:** In Appendix B-6-H of the Innovations waiver, core competencies are described regarding the Level of Care and the role of a care coordinator with this process. What are these core competencies and where are they described in more detail?	This is outside the scope of the RFA. This will be discussed in detail with selected LMEs.
6	Smoky Mtn	**DMA Contract 6.3 Emergency Medical Services:** What is the scope of fiscal responsibility for emergency medical services described in section 6.3 in the DMA contract? What are the billing/service codes that are included for reimbursement by the MCO and what are the criteria for identifying a behavioral health/ I-DD event in an emergency room?	Emergency medical services are calculated within the PMPM. The primary diagnosis at discharge is the criteria. Attachment V lists the ED services that the LME-MCO is responsible for if the primary discharge diagnosis falls in the psychiatric range.
7	Smoky Mtn	**Care Management: In section 6.13 in the DMA contract**, If a treatment plan or regular care monitoring is in place for an enrollee with special health care needs, the MCO shall allow enrollees to directly access specialists as appropriate for the enrollee's condition and identified needs. Is the term specialist limited to a behavioral health / I-DD care provider or does it include specialists outside of behavioral health? If yes, define what specialties would be included.	For any identified need, there must be a referral. The LME-MCO is required to link to any and all care and this is much broader that the MH/IDD/SA treatment realm. The LME-MCO is only responsible for paying for MHSAIDD care. The LME-MCO must familiarize themselves with all Medicaid-covered services.
8	Smoky Mtn	**Utilization Management, Section 7.4 DMA contract** states: The Innovations Utilization Management and Care Management (Tx Planning) sections of the MCO must be kept completely separate. Please define the extent of this separation in designing the administrative structure.	The LME-MCO must describe the safeguards to separate the UM and treatment planning processes. In other words, the Tx Planning department must not be in any way influenced by the UM Department.

#	Source	Question & Reference	Answer
9	Smoky Mtn	**DD Innovations:** The following language "reevaluations are conducted by the PIHP care coordinator" suggests that care coordination functions in the C waiver are PIHP staff at other times there seems to be an option of a care coordinator being a provider function with the PIHP.	No specific question is posed. Care Coordination = Managed Care Treatment Planning—the LME function.
10	Pathways	**DMA Contract, Section 7.7** Does the Request for Application Include management of State DD institutions (J. Iverson Riddle Center)?	The LME-MCO manages the Medicaid dollars for admissions. See the DMA Contract, section 7.7. All data is included in the Medicaid databook.
11	Pathways	**DMA Contract, Section 6.21** Does the Request for Application include management of State MH/SA institutions (state psychiatric hospitals and ADATCs)?	The LME-MCO manages the Medicaid dollars for admissions. See the DMA Contract (section 6.21) for those under age 18 and over age 63. All data is included in the Medicaid databook. See the DMHDDSAS Contract for those aged 18-63. Attachment III of the DMHDDSAS Contract states that transfer of funds for state facilities will not occur for the next "xx" years.
12	Eastpointe	**The draft MCO and DMA contract mentions in section 7.9** that the 270/271, 276/277 and 278 may be needed. Do these transaction sets need to be working at go live or can they be added later into the waiver contract if we are awarded the contract?	The transaction sets need to be working 60 days prior to start date, if not before.
13	Pathways	**On page 30 (top of page) of the sample DMA contract**, it relates that institutional care must be approved by a physician or PA. We need a definition of "institution." Do they mean state facility? Or IMD? If it's just more than a 16 bed facility that would mean all the hospital Medicaid admits would need a MD/PA approval by the MCO? That could be a huge cost increase. I also did not find what timeframe the hospital	Please read the CFR cited. A distinction is made in the contract between the MCO approving a request for any inpatient (hospital or IMD) and ICF and a physician or PA approving treatment in these facilities. An MD or PA must approve treatment at the facility. The list of behavioral health professionals in the CFR must approve the 'request.'

#	Source	Question & Reference	Answer
		admits would need to be approved within? Are those all prior authorizations or is there a 3 day processing time?	
14	Pathways	**Under Section 6.5** we need clarification of providers doing face-to-face contact within 1 hour for life-threatening emergencies (item e) versus emergency services within 2 hours (item a). Seems as though this applies both to new referrals and existing cases.	What is the question?
15	Pathways	**Under 6.6 Access Standards, of the sample DMA contract,** it says "MCO shall agree to provide services…" Do they mean through contract with a crisis provider? The section above is clear with this, but this one makes it seem like the MCO will provide the service directly.	Yes.
16	Pathways	**On the sample DMA contract, 6.9:** The term "designated emergency services facility" is used. Is this done through contracts with hospitals and/or an enhanced MHDDSA crisis service provider (detox, facility based crisis etc)? Would those then be the only places in our catchment that folks would need to go to for ES if they want authorization and full payment?	Yes. No.
17	Pathways	**On the sample DMA contract, 6.13: Care Management:** this section seems to contradict some others where it talks about the MCO "performing" activities that sound a lot like services. Such as A) perform telephone <u>assessment and crisis intervention</u>. Do you mean "screening"? Also under j., it says MCO shall produce a tx plan "…developed by enrollee's care manager." Does it mean through contract with a TCM provider? In most of the rest of the document the term	These are care management functions of the MCO and not provider services. Assessment and crisis intervention incorporates more than just screening. No.

#	Source	Question & Reference	Answer
		"care manager" refers to a staff function of the MCO.	

Questions about the DMHDDSAS Draft Contract

#	Source	Questions & Reference	Answer
1	Crossroads	**DMHDDSAS Contract, Attachment III** Does the Request for Application include management of State MH/SA institutions? If so, we need the data for what the dollars spent in this area would be (it is not in the Medicaid paid claims file).	The LME-MCO manages the Medicaid dollars for admissions. See the DMA Contract (section 6.21) for those under age 18 and over age 63. All data is included in the Medicaid databook. See the DMHDDSAS Contract for those aged 18-63. Attachment III of the DMHDDSAS Contract states that transfer of funds for state facilities will not occur for the next "xx" years.
2	Smoky Mtn	**DMHDDSAS Contract, Attachment III** Will state hospital dollars be included in the MCO single stream funding?	See the DMHDDSAS Contract. Attachment III of the DMHDDSAS Contract states that transfer of funds for state facilities will not occur for the next "xx" years. See above for inclusion of costs for IMDs in the Medicaid capitation.
3	Pathways	**DMHDDSAS Contract, Attachment III** Does the Request for Application include management of State MH/SA institutions (state psychiatric hospitals and ADATCs)?	The LME-MCO manages the Medicaid dollars for admissions. See the DMA Contract (section 6.21) for those under age 18 and over age 63. All data is included in the Medicaid databook. See the DMHDDSAS Contract for those aged 18-63. Attachment III of the DMHDDSAS Contract states that transfer of funds for state facilities will not occur for the next "xx" years.